THE UNIVERSITY of York

Foundation Trusts: A Retrospective Review

CHE Research Paper 58

Foundation Trusts: A Retrospective Review

Chris Bojke
Maria Goddard

Centre for Health Economics, University of York, UK

September 2010

Introduction

The recent health service reforms announced in the White Paper suggest an extended role in the NHS for foundation trusts (FTs) in future (Department of Health 2010). In particular:

- All trusts will become FTs within 3 years.
- A range of governance arrangement will be possible from employee-led only to wider public and patient membership.
- A range of increased freedoms will be consulted on, including abolishing the cap on earnings from sources other than NHS patients, facilitating mergers and the tailoring of governance arrangements to local needs.
- Monitor will be the economic regulator for all trusts whilst quality monitoring will be within the remit of the Care Quality Commission.

This report summarises briefly the evidence (as at February 2010) on FTs across a number of domains of relevance to the reforms.

Acknowledgements

We would like to thank Kath Wright in the Centre for Reviews and Dissemination for help with literature searching and Andrew Street and Alan Maynard for comments on an earlier version. The work was funded by the Department of Health in England as part of a programme of policy research at the Centre for Health Economics, University of York. The views expressed are those of the authors and may not reflect those of the funder.

Background to series

CHE Discussion Papers (DPs) began publication in 1983 as a means of making current research material more widely available to health economists and other potential users. So as to speed up the dissemination process, papers were originally published by CHE and distributed by post to a worldwide readership.

The CHE Research Paper series takes over that function and provides access to current research output via web-based publication, although hard copy will continue to be available (but subject to charge).

Disclaimer

Papers published in the CHE Research Paper (RP) series are intended as a contribution to current research. Work and ideas reported in RPs may not always represent the final position and as such may sometimes need to be treated as work in progress. The material and views expressed in RPs are solely those of the authors and should not be interpreted as representing the collective views of CHE research staff or their research funders.

Further copies

Copies of this paper are freely available to download from the CHE website www.york.ac.uk/inst/che/pubs. Access to downloaded material is provided on the understanding that it is intended for personal use. Copies of downloaded papers may be distributed to third-parties subject to the proviso that the CHE publication source is properly acknowledged and that such distribution is not subject to any payment.

Printed copies are available on request at a charge of £5.00 per copy. Please contact the CHE Publications Office, email che-pub@york.ac.uk, telephone 01904 321458 for further details.

Centre for Health Economics
Alcuin College
University of York
York, UK
www.york.ac.uk/inst/che

Summary

There is limited research evidence on foundation trusts (FTs) and much of the available material is in the form of commentary or the regular reports from Monitor. Comparative research is made difficult through lack of a counter-factual and robust methods are required to overcome bias. Summary points from the literature and from some initial analysis of Monitor reports that we have undertaken for this review are given below. Future policy and research issues are highlighted in the main report.

Corporate governance/accountability

- It is difficult to identify directly the degree to which the aims of 'social ownership' as expressed by the government at the launch of FTs have been achieved.
- There is emerging evidence to suggest that more experienced governors are more actively engaged with FT business but there are still challenges to be tackled, such as the degree to which engagement is in strategic rather than routine issues, and the ability of elected governors to feel they can represent constituency interests.
- The notion that FTs are more democratic in nature and are more accountable to local people has not really been supported by the research evidence.

Finance

- FTs have been successful in generating and accumulating financial surpluses, a process which appears to have been aided by FT status creating an incentive for improved financial practices. However, accumulation has been uneven across FTs.
- FTs are not using credit facilities to the anticipated extent, primarily due to a lack of larger-scale investment though credit availability may be becoming an issue. Instead limited investment has been mostly funded from existing surpluses. This has led to stockpiled and unused surplus held by FTs.
- FTs' ability to create surpluses may be under threat as a result of the recession.

Quality

- FTs generally score more highly in quality dimensions than non-FTs. However, given the weaker emphasis by Monitor on quality to date and the lack of strong incentives (as opposed to those for financial matters), this is likely to be more a function of the self-selection of the best-performing trusts to FT status, rather than a function of FT status itself.
- There have been a number of high-profile quality failures, some of which occurred some time after FT status had been achieved. The average quality rating has improved over time but there have been a number of trusts which systematically report 'red' risk ratings.

Regulation

- A major issue is the clarity and cost-effectiveness of the regulatory regime.
- The regulatory landscape will need to be clarified when all trusts become FTs as having separate regulators may be expensive and give rise to a lack of coherence.
- There is some evidence to suggest that the lack of clarity about roles and responsibilities has played a part in the failure to address serious performance issues in a timely fashion.

1. Introduction

The aim of this review is to provide to the Department of Health an overview of the evidence related to foundation trusts (FTs). It draws on the available research evidence and also on commentary from organisations and individuals. In addition, it provides a brief analysis of FT performance as a means of supplementing the sparse research literature. Four areas are considered below – corporate governance and accountability; finance; quality; and regulation. We conclude with some observations on future policy and research issues.

2. Corporate governance/accountability

2.1 Introduction

FTs are 'public benefit organisations' in which NHS staff and local citizens share in the governance of the organisation through their membership rights. Governors are elected by the members or are appointed by the PCT, Local Authorities and other partner organisations, and form the Board of Governors. Governors elected by public members must be in the majority on the Board which is recognised within the constitution of the trust.

Different types of role with various degrees of influence have been identified for the Board of Governors, but the thrust of the FT policy was to "…herald a new form of social ownership where health services are owned by and accountable to local people rather than Central Government. In this way, much stronger connections will be established between providers of NHS services and their stakeholder communities…" (DoH 2002).

As Allen (2006) notes, this aspect of FT policy was part of a broader decentralisation strategy in the public services aimed at tipping the balance away from the centre to allow greater autonomy whilst ensuring accountability at the local level. The issue of clinical governance and quality assurance is covered in sections four and five.

2.2 Evidence

Most research has aimed to (a) describe the operation of the governance arrangements in FTs in order to assess whether it accords with the initial policy aims, for instance by looking at the composition of membership in terms of local representation; and (b) assess the role of the governors in terms of their influence on health services, relationship with directors and the impact on accountability of the FT. The latter is clearly more difficult to assess and the evidence tends to be based on a small number of case studies and mainly on qualitative evidence gleaned from interviews or on survey data.

There was wide variation in the strategy followed by FTs to recruit members from the local community and most studies of original FTs suggest only modest success overall in terms of achieving large scale membership or a membership representative of local communities (Day and Klein 2005; Healthcare Commission 2005) with younger people and those from ethnic minorities under-represented. More recent research appears to be more positive with signs of increasing public membership and representation (Lewis and Hinton 2008; Lusk 2007). Moreover, some FTs are taking steps to profile their membership and to target specifically under-represented groups (eg the 'Young Supporters' programme in S Essex) (Ham and Hunt 2008).

The degree to which membership reflects 'active citizenship' rather than just appearing as members on paper, has been investigated through the voting behaviour of members in terms of turnout for election of Governors. The evidence on this is mixed as turnout appears highly variable. In early case studies, some very poor turnouts (on very small membership numbers) were reported– for instance Day and Klein (2005) noted that three governors in one FT were voted for by only 89 people from the local residents constituency. In contrast the Healthcare Commission (2005) found turnout rates of up to 70% amongst patient groups. Ham and Hunt (2008) looked at overall turnout in the six FTs in their study, which varied between 15% and 45% in 2007. There was no indication of a general improvement over time since 2004, and indeed, rates appeared to have declined in the established FTs. They also reported instances of governors standing unopposed or a lack of candidates and

resulting vacancies in some instances. However, in the established FTs, involvement by members was apparent, such as participating in seminars or open days. Many of these activities appear to be 'information giving' from the FT to members in the form of letters and briefings, rather than 'active' participation.

These potential shortcomings in terms of the breadth of membership and representation are in part likely to be a reason why research suggests that governors often find their relationship with the local constituents challenging. Whilst it is clear that governors believe they should be representing their local community and trust members, they do not always feel able to do so: whilst 90% of survey respondents agreed with their representation role, considerably fewer felt confident they are able to fulfil it (iPSOS MORI 2008). Only 8% of respondents selected 'effective representation of the community and trust members' as one of their achievements so far. Whilst there are some examples of FTs where governors hold constituency meetings successfully (Ham and Hunt 2008), the relationship does seem to be a difficult one at present.

Evidence on the relationship between governors and the board of directors and about the impact on services and work of the FT is more difficult to interpret. Again, early case studies seemed to suggest a lack of clarity about the role of Governors amongst the governors themselves, although FT directors appeared clearer. For instance, a study of a single FT over the first year of operation (Lewis and Hinton 2008) suggested there was confusion and lack of clarity amongst governors and directors about the different facets of the role of governor (e.g. advisory, guardianship and strategic) and that the governors made 'little tangible impact' on the running of the hospital and that the idea of influencing the management of the trust had not been achieved. The role of governor fell into that of 'consultation' and there was no discernable impact on strategy. The public governors who were elected locally felt very circumscribed in their role once elected. It was the first year of operation of the trusts so perhaps transformation was too high an expectation.

Taking a longer perspective, Ham and Hunt (2008), reporting on their study at six FTs at the end of 2007, suggested that, while such problems were common in early days of FTs, there were signs that "there is increasing clarity on the role of the board of governors and how the knowledge and skills of governors can be used to best advantage". They found that a number of governors were involved with the work on FTs in an active way although stakeholder governors were not as engaged.

A postal survey of FT governors (in all of the 73 FTs in existence at the time) undertaken on behalf of Monitor in 2007 also yielded more positive findings (iPSOS MORI 2008). In particular, 79% of governors agreed that they were clear about their role and responsibilities, although this was lower amongst more recent governors and the responses (response rate was 55%) were likely to come from those who were more actively engaged. Many were involved in sub-committees relating to trust business and this was an indicator of engagement. Most of these committees related to membership strategy, recruitment of chairs and non-executive directors and remuneration and only 12% reported being involved in sub-committees relating to strategy and only 15% said they would feel confident explaining strategy to a new governor. Attendance of governors at meetings of board of directors and at meetings between themselves appears highly variable (Ham and Hunt 2008, iPSOS MORI 2008).

In terms of impact, it is of course very difficult to attribute specific changes in services or strategy to the governance structure of FTs. FTs appear positive about their governance arrangements and suggest that there is greater consultation with members about services (Audit Commission 2008) and there are examples of good outcomes where governors have been directly involved with aspects of strategy development (Ham and Hunt, 2008). However, in responding to the governors' survey, 27% did not answer the question asking them to state the achievements they had made in their role so far (iPSOS MORI 2008). Whilst 13% said it was too early in their role to say, there was still a high proportion not able to specify any impact at all even when suggestions listed included relatively minor things such as becoming 'better informed'. When asked about how their achievements had benefitted others in the trust, patients or the community, the top ten answers had very low responses: the top was 7% for improved communications; only 3% said it had given patients a voice; and 40% did not answer at all.

Monitor's corporate strategy for 2009-12 includes several actions aimed at helping governors to understand their role and enhancing the way in which FTs engage with their membership (Monitor 2009f).

2.3 Conclusions

It is difficult to identify directly the degree to which the aims of 'social ownership' as expressed by the government at the launch of FTs have been achieved.

Research on the process of governance and the make-up of membership has been ambiguous but much of it focuses on early stages of the FT experience. There is emerging evidence to suggest that more experienced governors are more actively engaged with FT business but there are still challenges to be tackled, such as the degree to which engagement is in strategic rather than routine issues, and the ability of elected governors to feel they can represent constituency interests. The notion that FTs are more democratic in nature and are more accountable to local people has not really been supported by the research evidence. However, some FTs appear to be taking seriously the challenge of involving local communities in local health issues. The resource implications of such efforts and the degree to which they overlap or replace other channels for public involvement are not well documented.

Whilst it is possible to document the process of governance in terms of the nature of structures, potential for accountability and the opportunities for elected governors to attend meetings and influence directors of the FT, perhaps the most important issue is the degree to which the reduction in central accountability has been replaced by an effective means of local accountability. The running costs of the governance process were estimated at '*circa* £200,000 per trust' leading to estimated annual costs of over £25 million (House of Commons Health Committee 2008). It is important that evidence of an impact on the FT, local community and ultimately services is forthcoming.

The recent high-profile failings in clinical quality within a number of FTs suggest that gaps in the process of monitoring quality may exist. This is discussed in section four.

3. Finance

3.1 Introduction

The freedom of FTs to have greater autonomy in managing their own financial affairs and the ability to keep and ultimately invest, or borrow on the strength of, yearly surpluses is one of the key purposes underpinning the creation of FTs.

As good previous financial management was a qualifying condition for trusts to become FTs, simple comparisons of FTs against non-FT trusts may not be valid despite the common assertion that FTs are 'out-performing' non FTs financially. The only research that attempts to adjust for selection bias has concluded that there seem to be longstanding differential trends between these different groups of trusts and the FT policy per se has not made a significant difference to their financial management (Marini et al 2007). However, the research was based only on the early experience of FTs.

As all trusts will eventually become FTs, then the question of the difference the FT status makes to a trust relative to non-FT status may be of less policy interest than the financial performance of FTs over time. This is considered in the next section in terms of performance against the objectives set out for FTs: are FTs making surpluses and are they investing them in staff or capital projects which will benefit the population served?

3.2 Evidence

FTs are expected to generate surpluses that may be carried forward. To a large extent, this expectation has been fulfilled: In the first three years that FTs were operational, their cash surplus increased to £1.5 billion by the end of the first six months of 2007/08. This represented about 38 days of operating expenses (Audit Commission 2008). And the latest Monitor quarterly report states that

this stock of cash surplus has risen to £2.5 billion (Monitor 2009d). In conclusion, surpluses are clearly being generated and carried forward, though it should be noted that these surpluses are not evenly distributed across FTs.

The extent to which these surpluses are a function of FT status is debatable. However it has been acknowledged that the ability of an FT to keep surpluses has provided some degree of motivation in producing surpluses (House of Commons Health Committee Report 2008).

Despite the historical growth of surpluses, the current and future economic climate may provide more testing conditions. This is most easily observed via the quarterly and annual Financial Risk Ratings (FRR) produced by Monitor. FRRs are forward looking assessments presented as a scorecard, where a rating of 5 reflects the lowest level of financial risk and a rating of 1 the greatest. The risk rating is intended to reflect the likelihood of an actual or potential financial breach of the foundation trust's terms of authorisation based on four criteria: achievement of plan, underlying performance, financial efficiency, and liquidity.

These data are available on the regulators website from 2005 onwards in the form of 17 quarterly reports (Monitor 2005 – 2009d). Over this period 75% of risk ratings were at risk level 4 or 5 (the lowest risk ratings) though it should be noted that this data does not include the period in which Bradford Teaching Hospitals became engulfed in a financial crisis which eventually led to the removal of its chairman in December 2004.

We have constructed Figure 1 to show the FRR over time for the first 32 trusts which provided complete information over the period Monitor has published the quarterly risk ratings. The focus on the first FTs allows comparison of the performance of the same group of established FTs over time.

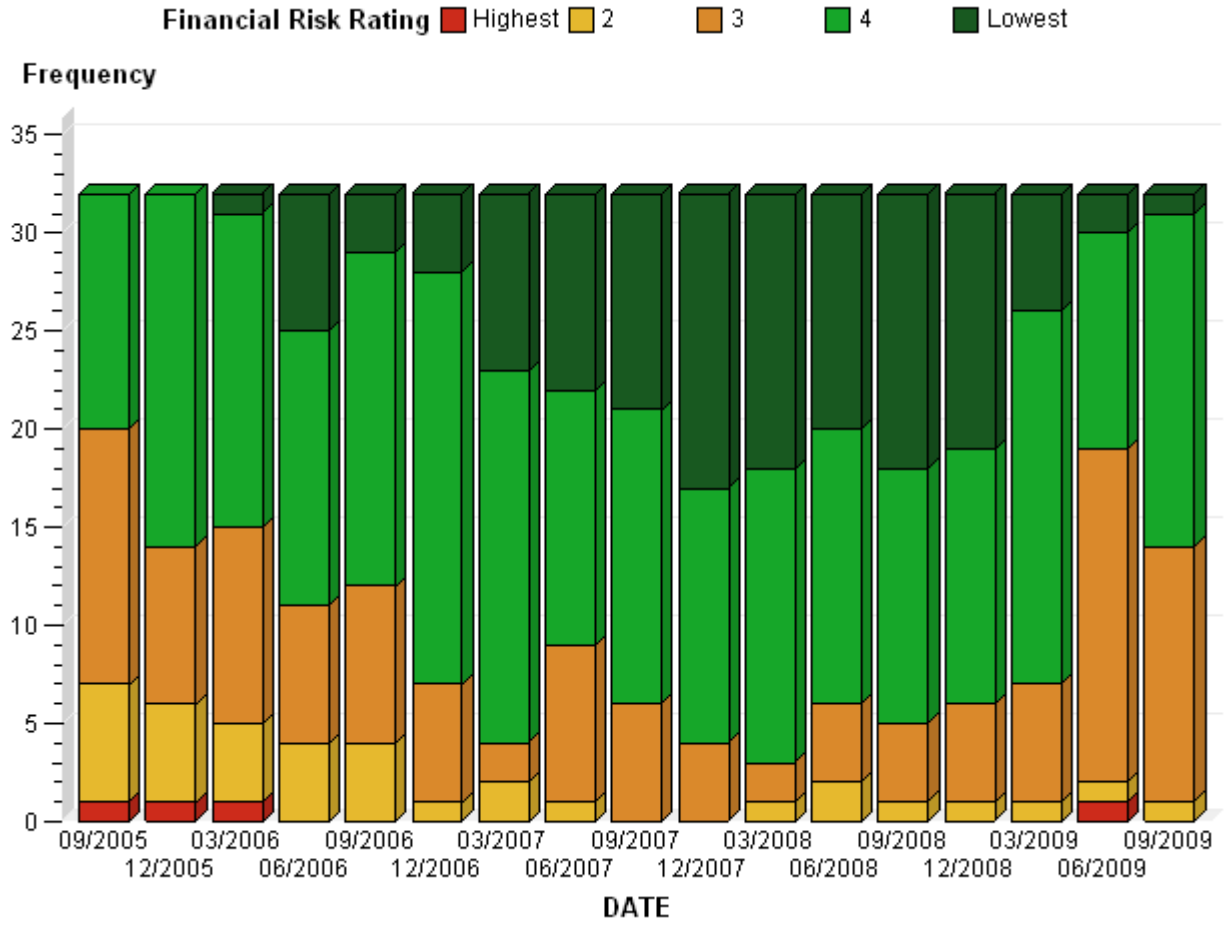

Figure 1

There are two noticeable trends in the data series. The first is a general improvement over time up to the period 12/2007 and 3/2008 as more and more FTs receive a risk rating in the 2 lower risk bands. The second trend is an increase in '3' ratings and reduction of '1' ratings from 06/2008 onwards. Although not shown here, a second tranche of the following 27 FTs show a similar initial pattern of improvement followed by an increase in '3' ratings and reduction of '1's from 2008 onwards.

The replication of the pattern across the different tranches and in particular the consistency of the increase in higher risk ratings from early to mid 2008 suggests that the financial climate may be at least partly responsible. Nevertheless, the financial autonomy given to FTs means that they themselves should be considering and adapting to the risk of potential financial shocks: the increase in higher FRRs indicates that this may not be the case. The Times reported that Mr Moyes said he had requested that foundation trust chief executives resubmit a 'downside assessment' — stripping back their budgets — to get a more realistic grasp of the funding pressures they faced, but was disappointed when, on being asked to revise their financial predictions in September, a number of trusts had resubmitted even more rosetinted forecasts of growth. (Lister 2010)

Thus although the evidence to date clearly shows that FTs are producing the expected surpluses, the (delayed) impact of the current financial climate may present a real threat to the ability of FTs to continue to produce such surpluses.

A second possible source of finance available to FTs is that provided by access to credit markets. In this respect however, FTs do not seem to be behaving as expected – "Monitor ... has found that FTs are not taking full advantage of their borrowing freedoms and have accessed only £100 million out of £2.5 billion available", (Audit Commission 2008).

The lack of borrowing may partly be a function of a lack of available credit, with commentators arguing that as hospital tariffs are in a constant state of flux this means that future income for FTs is uncertain (House of Commons Health Committee Report 2008) and that a lack of an insolvency regime means that private banks would be reluctant to lend (Mooney 2006).

But arguably the biggest factor is that FTs have not felt the need to borrow: it appears to be an issue of the demand for credit, rather than the supply of credit.

As the chairman of the regulator suggested: "Trusts are not clear where investment is needed. The second reason is that a lot of them are now planning investment in a piecemeal fashion; they are not looking to re-build the whole hospital but hospitals like Bradford ... are publishing ten year investment plans that can be done in chunks and they can largely raise the finance to do that from their own resources, from surpluses they are generating". (House of Commons Health Committee Report 2008)

Though there is no obvious cause for the lack of demand for credit (DoH 2009) there are two plausible suggestions. Firstly there is a lack of direction from PCTs, specifically what types of investments they would like to see the FTs engage in. Under such circumstances it is risky for FTs to engage in large scale investments that PCTs may not ultimately want. Secondly given the limited nature of the investment plans, it has not only been possible to fund these through accumulated surpluses, but an accumulation of surpluses has occurred that has no obvious immediate purpose.

The accumulation of unused surplus has itself been raised as an issue by the House of Commons Health Committee Report (2008) as there is the expectation that FTs would not retain large unused surpluses over time. However several FTs have reported stockpiling surplus to act as a buffer to the anticipated decrease in health funding and uncertainty surrounding the national tariff. Furthermore, it has not been an issue that has been highlighted at PCT level; "We tend as a PCT not to think about the surpluses; we tend to argue about our bottom line and coming in on budget" (John Carrier of Camden PCT). The future financial climate may change this perspective.

That is not to say there has been no capital investment or impact on services. For example the Christie Hospital has built radiotherapy centres across Greater Manchester and Cheshire (the first network of its kind in the UK) and Sheffield Teaching Hospitals are funding a £30 million critical care unit. Examples of other innovations in services such as "self pay" dermatology services also exist (HC and Audit Commission 2008). There are examples where it is claimed that FT status has enabled more speedy resolution of innovative deals, such as a FT and charity partnership to deliver mobile

chemotherapy services and a partnership with a private company to deliver IVF services for NHS and private patients (House of Commons Health Committee Report 2008). However, it is not straightforward to attribute such developments to FT status per se (as commissioners are being encouraged to develop and innovate in partnership with all providers, not just FTs) so there is little firm evidence about innovation of FTs, a point noted by the Health Committee in recommending that the government initiate evaluation of the extent of innovation by FTs (House of Commons Health Committee Report 2008).

3.3 Conclusions

FTs have been successful in generating and accumulating financial surpluses, a process which appears to have been aided because FT status creates an incentive for improved financial practices.

However, this position may change as a consequence of the current financial climate. Analysis of Monitor's reports suggests that after a sustained decrease in financial risk ratings, there has been an increase from mid 2008 and that current 3 year plans submitted by FTs are unduly optimistic.

FTs are not using credit facilities to the anticipated extent. This is primarily due to a lack of larger-scale investment plans and thus smaller scale investment has been mostly funded from existing surpluses.

This has led to stockpiled and unused surplus held by FTs - a situation which may have arisen partly as a result of a lack of direction from PCTs in terms of what investments they would like to see and also a general lack of concern about what FTs are doing with their surpluses. The changing financial climate may affect this lack of concern.

4. Quality

4.1 Introduction

Quality is a broad encompassing term covering many aspects of service provision including waiting times, convenience, etc. as well as conventional measures of clinical outcomes such as mortality rates and infection rates.

4.2 Evidence

It is arguable that quality has not received the same emphasis as financial matters in the build up to FT status. The Darzi report has helped focus attention on this factor, but the evidence on FTs and the quality of services is rather thin. As with finance "FTs are generally high performers in routine NHS process quality measures" though this finding again may be contaminated by the non-random selection of high-performing trusts to FT status (House of Commons Health Committee Report 2008).

However, as with finance, Monitor also produces quarterly Governance Risk Ratings (GRR) which attempt to capture these quality dimensions in a single measure on a 3 point scale ('red' – concerns that issue or issues significantly breach Terms of Authorisation; 'amber' – concerns about one or more aspects of governance; and 'green' – governance complies with terms of authorisation). We examine how the performance of the original 32 FTs is progressing and present our results below. The reporting of only 31 observations in 09/2006 is due to Moorfields Eye Hospital not receiving a GRR.

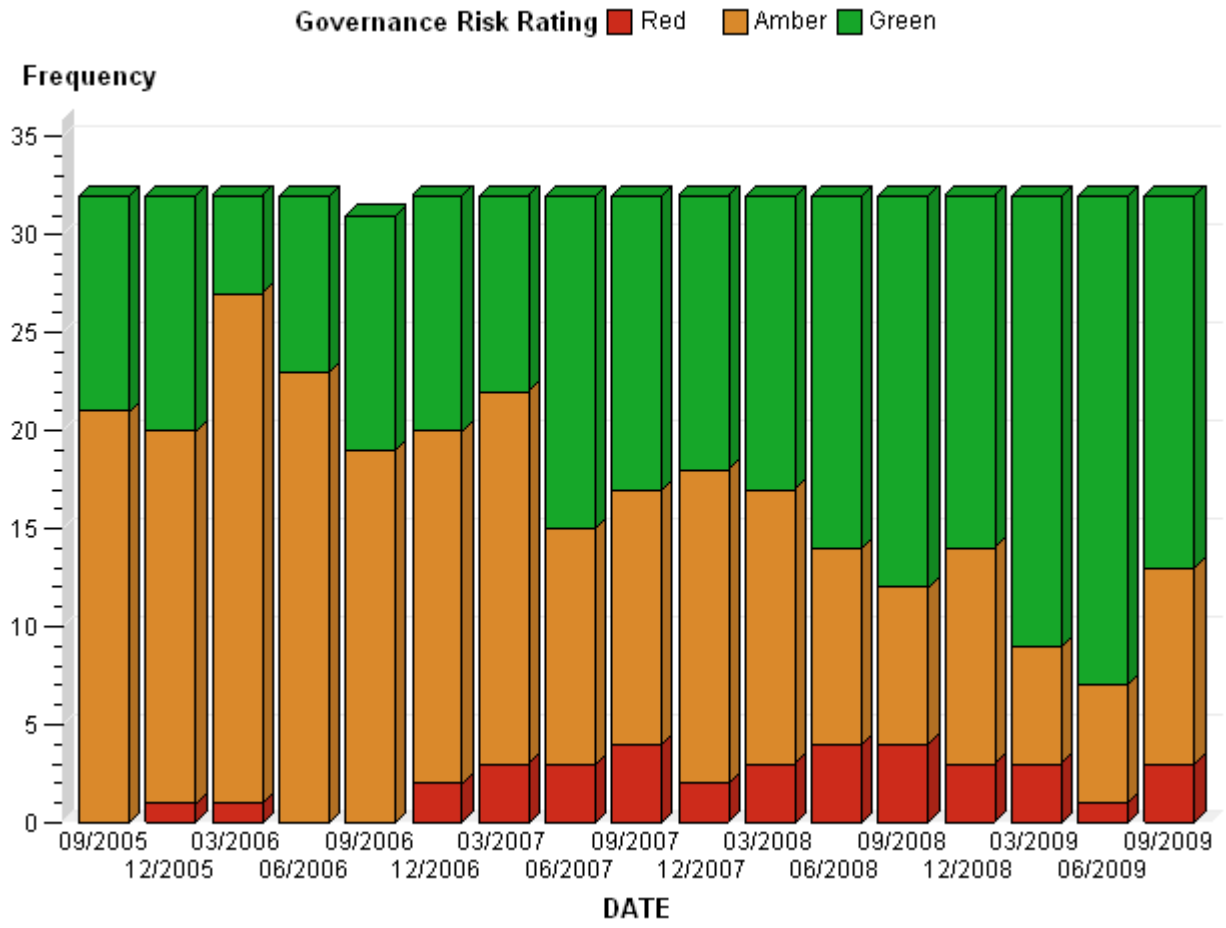

Figure 2

Figure 2 shows an increase in green rated FTs over time with either a blip or reverse in trend at 09/2009. As with the FRR this pattern is replicated with the next tranche of FTs (not shown). Although over time the average risk rating has fallen, there has been a persistence of 2 to 3 red-rated trusts which was largely absent over the first half of the time-series. Further examination reveals that it tends to be the same trusts that have these ratings, sometimes for a whole financial year. This feature was noted in the HoCHC 2008 report and drew a response that Monitor would 'instigate proceedings' if a trust remained with a red rating for more than two consecutive periods.

One such example is the Mid Staffordshire NHS Foundation Trust which, since its inception as an FT, has produced four consecutive amber ratings followed by three consecutive red ratings (March 2008 to September 2009). Although this has understandably produced bad headlines as a failing 'flagship' hospital, it is clear that these failings were present in 2007 - prior to the trust obtaining FT status (Alberti 2009). More recent examples include failings at Colchester Hospital University NHS Foundation Trust and nearby Basildon and Thurrock NHS Trust whose failings appear to have occurred after FT status was achieved.

4.3 Conclusions

FTs generally score more highly in quality dimensions than non-FTs, though given the lack of emphasis on quality and tailored incentives, this may be more a function of the self-selection of the best-performing trusts to FT status rather than a function of FT status itself. The Darzi report has placed greater emphasis on quality outcomes and this position may change in the future if quality-adjusted tariffs are implemented.

There have been a number of high-profile quality failures, with some very recent failures occurring some time after FT status has been achieved. And although the average quality rating has improved over time, there have been a number of trusts which systematically report 'Red' risk ratings over time.

5. Regulation

5.1 Introduction

The independent regulatory body called Monitor was introduced in 2004 to regulate FTs (Health and Social Care Act 2003). Monitor is responsible for authorising new FTs by ensuring they meet the required standards for licensing. It sets the financial and audit regime and also monitors FT performance (Monitor 2007e). Monitor's regulatory style reflects the greater autonomy granted to FTs by adoption of a proportionate risk approach in which well-managed and successful FTs are requested to provide minimal information to Monitor. It has a range of formal intervention powers to tackle problems that fail to be addressed through the normal assessment processes.

FTs are responsible to Monitor rather than to the Secretary of State but Monitor works alongside the recently formed Care Quality Commission (previously it worked mainly with the Healthcare Commission) to assess the performance of FTs against national targets and quality standards and states that it seeks to share information and intelligence with other regulators and to avoid duplication (Monitor 2009e).

5.2 Evidence

The aim of proportionate regulation means that formal intervention is a last resort for Monitor but in 2008-09 a number of cases required such action (Mid-Staffs and the Royal National Hospital for Rheumatic Diseases), ranging from requiring a review by the board, to replacement of senior posts including the chair and chief executive. A further 8 FTs were found to be in 'significant breach' of their authorisation and closer monitoring and reporting arrangements were set in place. The Monitor website lists 7 trusts that were subjected to formal interventions since 2005, with 4 of them occurring in October 2009 or later (Monitor 2010). These interventions are listed in the appendix.

One area that has received attention recently is the effectiveness of the assessment and regulatory regime operated by Monitor given the significant and high-profile failings related to quality of care, governance and leadership at Mid-Staffordshire FT just one month after it acquired FT status. The Healthcare Commission identified serious failings in the quality of emergency care at the Mid Staffordshire NHS FT and reported that the focus of the Board was on financial savings and securing FT status and that it lost sight of its responsibilities to deliver acceptable standards of health care (Healthcare Commission 2009). Whilst Monitor flagged up that it had previously taken some steps to address concerns, some commentators argue that Monitor was slow to spot these and that the intervention of the Healthcare Commission was required before more radical action was taken.

It is therefore informative to examine the risk ratings of trusts before intervention was required. In the case of Bradford and Mid-Staffordshire, their problems pre-dated either FT status or the current risk-rating procedure. However for the Royal National Hospital for Rheumatic Diseases, prior to the formal intervention, they had recorded four 'green' and one 'amber' rating in the previous five quarters for GRR and mostly '3's for FRR. For Heatherwood and Wexham Park there was half a year of 'green's and the lowest FRR prior to a sudden deterioration reported in March 2009 to a 'red' GRR and high FRR (Monitor intervened July 2009). And Basildon achieve a 'green' rating eight out of the previous nine periods prior to a 'red' triggering Monitor action.

Dorset and Colchester show less sudden paths to intervention. For Dorset a record of seven consecutive 'green' GRRs leads to two 'ambers' and then a 'red' in the final period. This is matched by a similar decline in FRR. For Colchester, there are again two 'amber' ratings preceding the 'red'.

Thus although there is no dominating pattern, the slight majority of trusts requiring intervention lurch into that position with little or no warning provided by the risk-rating structures. This may be because problems do develop very quickly or alternatively that the ratings (especially quality ratings) are not particularly useful as a signal of developing problems. There does appear to be some evidence that supports the latter conclusion as the risk-rating measures are based on self-assessments and self-certification. A recent Audit Commission report is critical, finding that there existed "significant gaps between the processes on paper and the rigour with which they are applied" and that "overall there was room for much improvement. In the worst cases, the assurance process had become a paper chase rather than a critical examination of the effectiveness of the trust's internal controls and risk

management arrangements. The NHS has, in many cases, been run on trust". The report noted that Mid-Staffordshire had certified that it was compliant with all core standards except that relating to waste disposal when subsequent examination revealed it had major failings in quality provision (Audit Commission 2009). This issue relates to the broader issue of the effectiveness of the performance assessment regime for all trusts, not just for FTs.

Relying on a more objective measure of outcomes, the Dr Foster health information guide lists 14 FTs as currently having significantly higher than average Hospital Standardised Mortality Ratios (HSMRs). Of these, four have had high rates for the past five years these being: Basildon, Royal Bolton, Tameside and Kettering General. Inspection of the GRR over the time periods for which they have provided risk ratings provides only one 'red' (the most recent Basildon GRR), fifteen 'ambers' and fifteen 'greens'.

Monitor has since reported that it has formalised the contact it has with the Care Quality Commission prior to authorisation of FTs and undertakes a more systematic review of clinical performance data from FT applicants. Monitor has also formalised the processes used to escalate regulatory issues when there are concerns about any aspect of FT's compliance with the terms of their authorisation. They suggest that their actions in relation to identifying those FTs at risk of not achieving nationally set targets for reductions in MRSA cases is an indication that their approach is working (Monitor 2010). In addition, there has been a focus on the role of the Board in leading on matters of clinical quality.

However, in the follow-up to the Mid-Staffs case, concern has been expressed that one element of failure related to the overlapping responsibilities and roles of different parties, including the trust, PCT, StHAs and regulators and that some issues and responsibilities appear to fall between organisations (Thome 2009). In addition, it was noted that FTs at times make themselves 'somewhat inaccessible' to their commissioners. This was not seen as acceptable when the FTs are part of the NHS and must be accountable to commissioners for the quality of care.

Whilst there has been an emphasis by Monitor on their role in co-operating and sharing information with 'appropriate' partners (Monitor 2010), there have been signals of some tension between the boundaries of the regulators. In 2008, the NHS Chief Executive included FTs in his circular instructing all trusts on detailed matters of infection control following an outbreak at one hospital. The media reported that the Chief Executive of Monitor was not pleased with the instructive tone of the letter and queried whether in was in contravention of legislation because it implied a direct line management accountability between FTs and the Department of Health (HSJ 2008). The Chief Executive of Monitor subsequently suggested that issuing guidance to commissioners, rather than direct to providers, is a more appropriate route by which the Department of Health can express concerns about detailed aspects of service provision (Health Care Commission 2005)

Similar issues arose after the Darzi report indicated that a proposed new regulatory agency would be responsible for registration and de-registration of FTs, a proposal to which Monitor objected. Issues concerning lines of accountability arose in response to government proposals in the Health Bill which required quality accounts to be sent to the Health Secretary, which Monitor perceived as a potential threat to the independence of FTs. The FT Network has highlighted the perceived conflict between central controls and targets and the independence of FTs and argues for local targets to be set by FTs with their partners (FTN 2005).

Monitor's approach to regulation that stresses the autonomy of FTs has also raised questions about the reporting responsibilities and the accountability of FTs. In addition to concerns expressed by the review of the Mid-Staffs case, and about the transparency and availability of comparative financial information for evaluation purposes (House of Commons Health Committee 2008), there are reports of a lack of transparency in other areas also. Woodward et al (2009) looked at the online availability and accessibility of the minutes of recent director's board meetings, comparing random samples of FTs, non FTs and PCTs. A higher proportion of minutes were not available in FTs (37.5%) than in non-FTs (7.9%). Some FTs stated that director's board meetings are, or would be, held in private but governors board meetings were public and minutes available. The option for holding private board of directors meetings is available only to FTs and Woodward notes that Mid-Staffs held private meetings and did not publish minutes. The Healthcare Commission also noted that the board did not routinely

discuss issues of quality of care and Woodward comments that greater public scrutiny may have influenced the way in which boards conduct and report on trust business.

Anecdotally there appears to be concern with perceived secretiveness of FTs in relation to other types of data, for example, on pay levels (reported by the RCN, (Taylor, 2007)). Actions such as these appear at odds with the original intention that FTs would have stronger connections to their local stakeholders and suggest that there might be an imbalance between autonomy and accountability. Similar issues of accountability arise in the relationship between PCTs and FTs and early research on 'earned autonomy' (the pre-cursor policy to the introduction of FTs) highlighted some potential concerns that trusts viewed enhanced autonomy, and ultimately FT status, as a means to shift the balance of power away from commissioners towards providers (Goddard and Mannion 2006). Subsequently, commentators have noted that PCTs perhaps should have been strengthened and given more power or autonomy *before* the provider side was strengthened through FT status (reported in Mooney 2009). The introduction of PbR potentially strains relationships further because in the absence of demand control, there is little PCTS can do to prevent over-trading on the part of FTs and the creation of subsequent financial difficulties for the PCT.

Having identified issues within FTs the next question is whether Monitor's intervention is effective. Evidence for this is provided by Monitor's self-commissioned evaluation report regarding its impact. With respect to the four case studies regarding concerns over the financial positions of trusts (Bradford, Homerton University, Royal Devon and Exeter and UCLH) they estimated that they caused a reduction in deficit of £16 million and faster recovery savings of £20-£25 million for Bradford and Royal Devon. In terms of governance, there was no analysis of an intervention effect. (Frontier Economics, Monitor 2009).

The relationship between Monitor and the CQC and also other regulators, will need attention especially as more trusts become FTs. In addition to ensuring clarity about roles in order to ensure there are no gaps, there may also be efficiencies in combining some or all regulatory functions. Monitor's operating costs were £16.2m in 2008/9 (Monitor, 2009). The position of the CQC is more difficult to assess given it was in a transition phase and responsible for overseeing the merger of regulatory bodies into the new organisation. They report an operating budget of £166.8m for 2009/10 (CQC 2009). The NHS Co-operation and Competition Panel has also recently entered the regulatory arena.

5.3 Conclusions

A major issue is the clarity and cost-effectiveness of the regulatory regime. On one hand there is a need to avoid duplication and excessive demands on providers and attempts to control everything from the centre; and on the other the need to ensure there are clear roles and responsibilities for regulators and other organisations such as StHAs and PCTS, without gaps arising, and that accountability for the use of public money is ensured.

The regulatory landscape will need to be clarified when all trusts become FTs as supporting separate regulators may be expensive and produce a lack of coherence. There is some evidence to suggest the lack of clarity about roles and responsibilities has played a part in the failure to address serious performance issues in a timely fashion.

6. Research and policy issues

Overall there is limited research evidence on foundation trusts and much of the available material is in the form of commentary or the regular reports from Monitor. Comparative research is made difficult through lack of a counter-factual and robust methods are required to overcome bias. The majority of evidence originates from qualitative research on the nature and impact of the FT governance arrangements in relation to the role of governors and the impact of public membership.

Measuring the impact of the FT governance arrangements is difficult to do other than in a qualitative way. Current research of which we are aware includes an SDO funded study on the governance of FTs based around four case studies (Allen et al; due to report end 2010) investigating the internal and external governance arrangements for FTs and comparing the effectiveness of arrangements with

those of non-FTs. Gathering evidence on the estimated costs of the FT governance arrangements would be a useful addition to the literature on effectiveness and impact and would inform judgements about the degree to which FTs should retain (and replicate) these as the policy rolls out to all trusts.

An updated and extended version of the quantitative analysis of FT performance undertaken previously at the Centre for Health Economics, University of York (Marini et al, 2008) is underway and will report later in 2010. This research employs robust methods in order to account as far as possible for selection bias and will provide evidence on the more recent performance of FTs than was possible in the original work. Further extensions of this work to include more variables of interest and more years of data would be useful, although accessing relevant data is not always straightforward as FTs do not have to report data to the centre in the same way as other trusts and there is not always a willingness on the part of Monitor or the FTs to provide the information for research.

Given the challenges of comparative analysis of FTs and non-FTs, there is also merit in exploring the performance of FTs over time. The illustrative analysis of finance and performance presented in this review is a starting point for a more sophisticated analysis that separates out the underlying difference between trusts as they become FTs and their performance over time.

Identification of the extent to which the FT regime has enabled innovative service development that would not have otherwise taken place, seems worthwhile although challenging in terms of establishing the counter-factual. However, drawing together evidence and examples from across the StHAs in a comprehensive way may be a good starting point.

There are a number of policy and research issues around the future regulatory regime in the NHS. Following the consolidation of some regulatory functions into the CQC and as more trusts become FTs, there is scope to consider the cost-effectiveness of the separation of regulators. This could potentially be informed by experience in other sectors and in the healthcare sector, internationally.

The effectiveness of the current regulatory regime as a means of signalling potential quality failings in a timely way is an issue that goes beyond the FT regime but is of great importance in the broader NHS.

7. Appendix A

7.1 Formal Monitor interventions

Bradford Teaching Hospitals (2004): Two actions in late 2004 the first of which was to require the appointment of external advisers, and shortly after, the appointment of a new chair. The steady improvement in its financial performance meant the trust returned to quarterly monitoring in 2006, in line with the majority of NHS foundation trusts.

Royal National Hospital for Rheumatic Diseases (2008): In April 2008 the trust identified a significant control weakness in the trust's accounts leading to a changed financial risk rating of 2 in quarter 4 of 2007-08. On 4 August 2008 Monitor used its formal powers to intervene with an aim to ensuring that appropriate regulatory control was in place to assist in the maintenance and protection of trust services for patients. In December 2008, Monitor's Board decided to intervene for a second time, in order to secure the resources and skills required to deliver the trust Board's strategy and longer term financial stability and in April 2009, Monitor's Board intervened for a third time to appoint an Interim CEO and Interim Chair.

Mid Staffordshire (2009): In March 2009 Monitor used its formal powers to replace and appoint an interim Chief Executive replaced by a permanent appointment in July/August 2009. Monitor continues to hold Mid Staffordshire NHS Foundation Trust to account at each step towards delivery of its Transformation Plan.

Heatherwood and Wexham Park Hospitals (2009): In July 2009, Monitor found the trust to have suffered a rapid decline in financial and operational performance. As a result the trust was required to submit a recovery plan, presented to Monitor in October. Monitor's Board did not consider that this plan was robust enough to ensure the trust's return to a sustainable position, or that it demonstrated

that the trust had in place the board and clinical leadership necessary to achieve this. In October 2009, Monitor intervened again appointing an interim chair.

Dorset County Hospital (2009): In October 2009, Monitor found the trust to be in significant breach of its terms of authorisation due to a failure to comply with its general duty to exercise its functions effectively, efficiently and economically. Monitor used its formal powers of intervention to appoint - with immediate effect - an Interim Chair at the trust.

Basildon and Thurrock University Hospital (2009): In November 2009 Monitor found the trust to be in significant breach of its terms of authorisation due to concerns around leadership and quality of care at the trust. Monitor is requiring the trust board to use an expert taskforce to manage and report on the delivery of plans to improve quality of service; agree with Monitor the objective performance metrics against which the trust's performance will be measured and reviewed monthly; and take immediate steps to strengthen senior clinical capacity, in particular, to provide additional support to the Medical Director and Director of Nursing.

Colchester Hospital University (2009): In November 2009 Monitor found the trust to be in significant breach of its terms of authorisation due to the trust's failure to comply with healthcare standards; its failure to exercise its functions effectively, efficiently and economically; and serious and wide ranging concerns as to overall governance and leadership at the trust. Monitor used its regulatory powers to remove the Chair of the trust with immediate effect and appoint an interim Chair.

Although not listed as a formal intervention, Monitor did appoint a turn-around team for University College London Hospitals (2005) with the aim of recovering patient activity lost during transfer to new hospital premises and the financial overspend this caused in August 2005 As a result the annual overspend trend was reversed and a surplus position achieved in 2007/08.

As four of the FTs that have only recently required intervention it is difficult to judge whether such intervention has been successful. However looking at the earlier interventions, Whilst Bradford appears to have made a full recovery, RNHRD has recorded its sixth successive 'red' rating for GRR and seventh successive 1 or 2 high risk rating in FRR.

8. References

Alberti G (2009) Mid Staffordshire NHS Foundation Trust: A review of the procedures for emergency admissions and treatment, and progress against the recommendation of the March Healthcare Commission report. Also available at http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098662.pdf

Allen P. New localism in the English NHS: what is it for? (2006) *Health Policy*, 79: 244- 252.

Audit Commission (2008) Is the treatment working. Progress with the NHS system reform programme. Available at http://www.audit-commission.gov.uk/nationalstudies/health/financialmanagement/pages/isthetreatmentworking.aspx

Audit Commission (2009) Taking it on trust – A review of how boards of NHS trusts and foundation trusts get their assurance. Available at http://www.audit-commission.gov.uk

Care Quality Commission (2009) Report and Accounts for the period 1 October 2009 to 31 March 2009. July 2009
Available at http://www.cqc.org.uk/_db/_documents/CQC_reports_and_accounts.pdf

Day P and Klein R (2005) *Governance of Foundation Trusts: dilemmas of diversity*. The Nuffield Trust, London.

Department of Health (2002) A guide to NHS Foundation Trusts, Department of Health:London. Also available at http://www.dh.gov.uk/assetRoot/04/06/04/80/04060480.pdf

Department of Health (2009) The Government response to the Health Committee Report into Foundation Trusts and Monitor, Department of Health: London Also available at http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_094442.pdf

Department of Health, 2010, *Equity and excellence: liberating the NHS*. London, Department of Health.

Frontier Economics and Monitor (2009) Measuring Monitor's impact: Economic evaluation report. Available at http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/about-monitor/what-we-do/measuring-monitors-impact-economic-ev

Foundation Trust Network (2005) Foundation Trusts: future thinking, challenges and change. Foundation Trust Network, London

Goddard M, Mannion R (2006) Decentralising the NHS: rhetoric, reality and paradox. *Journal of Health Organisation and Management* 20 (1) p67-73

Ham C, Hunt P (2008) *Membership governance in NHS Trusts: a review for the Dept of Health*. July 2008. University of Birmingham and Mutuo

Health and Social Care Act (2003) The Health and Social Care (Community Health and Standards) Act. Also available at http://www.opsi.gov.uk/acts/acts2003/20030043.htm

Healthcare Commission (2005). The Healthcare Commission's Review of NHS Foundation Trusts, Healthcare Commission, London, 2005. Also available at http://www.healthcarecommission.org.uk/_db/_documents/04018494.pdf

Healthcare Commission (2009), *Investigation into Mid Staffordshire NHS Foundation Trust*, London: The Healthcare Commission.

Healthcare Commission and Audit Commission (2008) *Is the Treatment Working? Progress with the NHS system reform programme*. London: The Healthcare Commission.

Health Services Journal (2008). Monitor challenges DH on freedoms. 22 February.

House of Commons Health Committee (2008) *Foundation trusts and Monitor*. Sixth Report of Session 2007-08. Volume 1

Ipsos Mori Social Research Institute (2008) *Survey of Foundation Trust Governors: research study conducted for Monitor – independent regulator of NHS Foundation Trusts.* Available at: *http://www.monitor-nhsft.gov.uk/sites/default/files/publications/Ipsos_MORI_survey_FT_governors_June2008.pdf*

Lewis and Hinton (2008) Citizen and staff involvement in health service decision-making: have National Health Service foundation trusts in England given stakeholders a louder voice? *Journal of Health Services & Research Policy*. 13(1) 19-25

Lister S (2010) Hospitals must cut services to stay afloat, watchdog warns. The Times (January 22, 2010). Also available at http://www.timesonline.co.uk/tol/life_and_style/health/article6997644.ece

Lusk F. (2007) Are Foundation Trusts a good thing? Issues for community stakeholders. *Journal of Integrated Care*, 15(1): 20-23.

Marini G, Miraldo M, Jacobs R and Goddard M 2007 Foundation Trusts in the NHS: does more freedom make a difference. *Health Policy Matters*. 13. Also available at http://www.york.ac.uk/healthsciences/pubs/hpm13final.pdf

Monitor (2005) NHS foundation trusts: Six-month report for period 1 April to 30 September 2005. Also available at http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-quarterly-reports

Monitor (2006a) NHS foundation trusts: Nine-month Report for period 1 April 2005 to 31 December 2005. Also available at http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-quarterly-reports

Monitor (2006b) NHS foundation trusts: Plan for 2006-07 and Report for Period 1 April to 30 June 2006. Also available at http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-quarterly-reports

Monitor (2006c) NHS foundation trusts: Report for six-month period to 30 September 2006. Also available at http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-quarterly-reports

Monitor (2007a) NHS foundation trusts: Report for Nine Months to 31 December 2006. Also available at http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-quarterly-reports

Monitor (2007b) NHS foundation trusts: Report for Year Ended 31 March 2007. Also available at http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-quarterly-reports

Monitor (2007c) NHS foundation trusts: review of three months to 30 June 2007. Also available at http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-quarterly-reports

Monitor (2007d) NHS foundation trusts: review of six months to 30 September 2007. Also available at http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-quarterly-reports

Monitor (2007e). About Monitor: effective regulation, better patient care. December. Available at http://www.monitor-nhsft.gov.uk/publications.php?id=1069

Monitor (2008a) NHS foundation trusts: review of nine months to 31 December 2007. Also available at http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-quarterly-reports

Monitor (2008b) NHS foundation trusts: review of twelve months to 31 March 2008. Also available at http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-quarterly-reports

Monitor (2008c) NHS foundation trusts: review of three months to 30 June 2008. Also available at http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-quarterly-reports

Monitor (2008d) NHS foundation trusts: review of six months to 30 September 2008. Also available at http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-quarterly-reports

Monitor (2009a) NHS foundation trusts: review of nine months to 31 December 2008. Also available at http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-quarterly-reports

Monitor (2009b) NHS foundation trusts: review of twelve months to 31 March 2009. Also available at http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-quarterly-reports

Monitor (2009c) NHS foundation trusts: review of three months to 30 June 2009. Also available at http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-quarterly-reports

Monitor (2009d) NHS foundation trusts: review of six months to 30 September 2009. Also available at http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-quarterly-reports

Monitor (2009e) Annual report and accounts 1 April 2008 – 31 March 2009. Also available at http://www.monitor-nhsft.gov.uk/sites/default/files/Monitor%20Annual%20Report%20and%20Accounts%202008%2009.pdf

Monitor (2009f) Corporate Plan 2009-12. May 2009 [online] http://www.monitor-nhsft.gov.uk/sites/default/files/Monitor_CorporatePlan_May09_onlinev2.pdf

Monitor (2010) Formal Interventions [online] http://www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/regulatory-action/formal-interventions-0

Mooney H (2006) When will ministers allow foundation trusts to fail. *HSJ* 116 5995 p14-15.

Mooney H (2009) Foundation Trusts: breaking free. *HSJ* 2 119 6150 22-24

Taylor, J. (2007). Why nurses are thriving at foundation trusts. *Nursing Times* 103(29): 16-18.

Thomé C David (2009) Mid-Staffordshire NHS Foundation Trust: a review of lessons learnt for commissioners and performance managers following the Healthcare Commission investigation. Available at: http://www.midstaffsinquiry.com/assets/docs/Colin-Thome%20report.pdf

Woodward V, Endacott R, Sheaff R and Jones R (2009) Obtaining corporate information from NHS foundation trusts. *Nursing Standard* 23;43 p35-37